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STATE OF DELAWARE

BOARD OF EXAMINERS OF PSYCHOLOGISTS

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PSYCHOLOGICAL ASSISTANT REPORT OF RELEASING SUPERVISOR

INSTRUCTIONS

A change in a Psychological Assistant's supervising Psychologist must be reported by the Psychological Assistant and *both* the new and releasing supervisors, as follows:

- The Psychological Assistant and the proposed ***new*** supervisor must complete and submit the *Psychological Assistant Report of New Supervisor* form.
- The Psychological Assistant and the ***releasing*** supervisor must complete the *Psychological Assistant Report of Releasing Supervisor* form.

In addition to reporting the supervisory change, the *Psychological Assistant Report of Releasing Supervisor* form documents the duties performed and the hours of post-doctoral supervised experience gained during the period that the Psychological Assistant was under the releasing Psychologist's supervision.

Submit a completed, signed and notarized *Psychological Assistant Report of Releasing Supervisor* form. Both the Psychological Assistant and the new supervising Psychologist must sign the form in the appropriate places.

INFORMATION ABOUT PSYCHOLOGICAL ASSISTANT – The Psychological Assistant completes this section

1. Name: _____ _____ _____
   Last First Middle
2. Delaware License Number: **B2** - _____
3. Mailing Address:_____
   _____ _____ _____
   City State Zip
4. Phone: _____ _____ Email: None ☐_____
   Daytime Home

AFFIRMATION BY PSYCHOLOGICAL ASSISTANT

I hereby report this change in supervising Psychologist. I further acknowledge that I have read the Delaware psychology Statute and Rules and Regulations pertaining to the psychological assistants and that I agree with the training program/duties as stated and the hours of experience as reported. I further swear or affirm that I understand that any intentionally fraudulent information will be reported to the Attorney General.

Assistant Signature: _____ Date: _____

INFORMATION ABOUT RELEASING SUPERVISOR – The releasing supervising Psychologist completes this section.

5. Supervisor's Name: _____ _____ _____
   Last/Family Name First Middle
6. Supervisor's Title: _____ Degree: _____
7. Delaware License Number: **B1** - _____ Issue Date: _____

8. Practice Address: _____

_____ _____ _____
City State Zip

9. Phone: _____ _____ Email: None ☐_____
Daytime Home

10. Supervision Start Date: _____/_____/_____ Completion Date: _____/_____/_____

VERIFICATION OF POST-DOCTORAL PROFESSIONAL EXPERIENCE – The releasing supervising Psychologist completes this section.

11. During the period you supervised the Psychological Assistant, what was his or her professional identity?

☐ Psychologist ☐ Psychological Intern

☐ Registered/Certified Psychologist ☐ Trainee

☐ Registered Psychological Assistant ☐ Other: Specify: _____

12. Were you providing professional services at least 50% of the time in the same work setting where the applicant was gaining supervised professional experience? Yes ☐ No ☐

13. Describe *in detail* the training program and/or psychological duties the Psychological Assistant performed under your supervision.

_____

_____

_____

_____

_____

_____

_____

14. I would rate this Psychological Assistant's performance while under my supervision as (check <u>one</u>):

☐ Acceptable ☐ Not Acceptable ☐ Unable to Evaluate

15. Provide the following information about the hours that the Psychological Assistant worked under your supervision. Note that the hours you enter must be exact *numbers*.

LOCATION OF SUPERVISION	DATES (month/day/year)		TOTAL WEEKS WORKED	HOURS WORKED PER WEEK	TOTAL HOURS WORKED FOR ENTIRE PERIOD	HOURS OF DIRECT CLINICAL SERVICE PER WEEK	TOTAL HOURS OF DIRECT CLINICAL SERVICE FOR ENTIRE PERIOD
	From	To					

16. Provide a detailed breakdown of each type of supervision. *Note that the TOTAL must meet requirements of Section 7.2 of the Rules and Regulations:*

FORMAT OF SUPERVISION	HOURS PER WEEK
Individual Supervision:	
Group Supervision:	
Other Supervision – specify: _____	
TOTAL	

Include any other information you consider to be relevant on a separate page.

AFFIDAVIT

I hereby swear or affirm that the information contained in this form is correct and I understand that any intentionally fraudulent information will be reported to the Attorney General.

Releasing Supervisor Signature: _____Date: _____

County of_____ State of _____

Sworn or affirmed before me a Notary Public this _____day of _____, 2_____

Notary Signature: _____

SEAL

My commission expires on: _____

Mail this form *directly* to the Board office at the address above.